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14 **UNITED STATES DISTRICT COURT  
15 EASTERN DISTRICT OF WASHINGTON**

16 ERIC WRIGHT, INDIVIDUALLY  
17 AND IN HIS CAPACITY AS  
18 PERSONAL REPRESENTATIVE  
19 OF THE ESTATE OF STEVEN O.  
20 WRIGHT; AND, AMY SHARP,  
21 INDIVIDUALLY,

22 No. 2:15-cv-00305-TOR

23 DECLARATION OF  
24 BRUCE WAPEN, M.D. IN  
25 OPPOSITION TO UNITED  
26 STATES' MOTION FOR  
SUMMARY JUDGMENT

27 Plaintiffs,

28 v.

29 THE UNITED STATES OF  
30 AMERICA; MEDFORD  
31 CASHION, M.D.; STAFF CARE,  
32 INC.,

33 Defendants.

1                   BRUCE WAPEN, M.D. swears under penalty of perjury as follows:

2                   1. I am over the age of 18 years and competent to testify to the matters  
3 stated herein, and I make this Declaration based on personal knowledge.

4  
5                   2. I have practiced emergency medicine for 37-years (1976 through  
6 2013) and have been board certified in emergency medicine for 30-years (1984  
7 through 2014). I am licensed to practice medicine in the States of California &  
8 Washington. I am familiar with the standard of care for emergency physicians  
9 and have qualified as an expert witness in emergency medicine at trials in the  
10 States of California, Alaska, Idaho, Michigan, Arizona, New Mexico and  
11 Nevada. The opinions expressed in this report are based on knowledge obtained  
12 through my education, training and experience as well as from research specific  
13 to this case.

14  
15                   3. I have been retained by counsel for Plaintiff to render opinions  
16 regarding the medical management of Steven O. Wright in the Emergency  
17 Department (ED) at the Veteran Affairs Medical Center in Spokane, WA on 2  
18 August 2014. At the time of this event, I had been retired from the active practice  
19 of emergency medicine for 8-months; but I was still board certified in emergency  
20 medicine.

1       4. In preparing this Declaration, I have reviewed the following  
2 documents:

3       -Veteran Affairs Medical Center ED records 8-2-14, visits # 1 & #2  
4       -Certificate of Death 8-11-14  
5       -Autopsy Report 8-12-14  
6       -Institutional Disclosure of Adverse Event 8-12-14  
7       -Plaintiff's Initial Discovery 2-26-16  
8       -Depositions of: Medford Cashion, MD; Shea McManus, MD; Karla  
9       Linton, LPN; Robert Ready, RN; Jill Palmer, RN; Kimberly Morris, MD;  
10       Elizabeth Whitley Ford, RN; and Matthew Haugen, RN  
11       Elizabeth Whitley Ford, RN; and Matthew Haugen, RN  
12       Elizabeth Whitley Ford, RN; and Matthew Haugen, RN  
13       Elizabeth Whitley Ford, RN; and Matthew Haugen, RN  
14       5. In preparing this report, I have researched information from the  
15 following sources:  
16       -ACEP Clinical Policy: Neuroimaging and Decision Making in Adult Mild  
17       Traumatic Brain Injury in the Acute Setting, *Annals of Emergency  
18       Medicine*, Volume 52, No. 6: pages 714-727, December 2008.  
19       -David W. Wright & Lisa H. Merk, "*Head Trauma in Adults and  
20       Children*," *Tintinalli's Emergency Medicine: A comprehensive Study  
21       Guide - 7th Edition*, pages 1692-1709, 2011.  
22       -Karni A, Holtzman R, Bass T, et al: Traumatic head injury in the  
23       anticoagulated elderly patient: a lethal combination, *Am Surg* 67(11): 1098,  
24       2001.  
25       -Mina AA, Knipfer JF, Park DY, et al: Intracranial complication of  
26       preinjury anticoagulation in trauma patients with head injury, *J Trauma*  
26       53(4): 668, 2002.  
26       -Cohen DB, Rinker C, Wilberger JE: Traumatic brain injury in  
26       anticoagulated patients, *J Trauma* 60(3), 553, 2006.

1                   -Mack L, Chan S, Silva J, et al: The use of head computed tomography in  
2 elderly patients sustaining minor head trauma, *J Emerg Med* 24:157-162,  
3 2003.

4                   -Ohm C, Mina A, Howells G, et al: Effects of antiplatelet agents on  
5 outcomes for elderly patients with traumatic intracranial hemorrhage. *J Trauma* 58: 518-522, 2005.

6                   **I. Factual Summary of Events**

7                   6. Steven O. Wright ("SW"), a 70-year-old male, presented to the  
8 Spokane, WA Veteran Affairs Medical Center ED accompanied by a friend at  
9 about 11:00am on 8-2-14. SW complained of a left knee injury secondary to a  
10 fall down two steps on 7-27-14. He had been using crutches to help him walk but  
11 complained of pain, swelling and bruising in this left leg. He was evaluated by  
12 Dr. Shea McManus. The left leg displayed swelling and purplish discoloration  
13 from the distal thigh to the foot with "severe anasarca/edema," but no such  
14 swelling of the right leg or scrotum was noted. (Anasarca: generalized massive  
15 edema [Dorland's Illustrated Medical Dictionary - 30<sup>th</sup> Edition])

16                   7. It was documented that SW was taking the anticoagulant warfarin  
17 (Coumadin) for treatment of chronic atrial fibrillation (A-fib) as well as a baby  
18 aspirin a day (both are blood-thinners, but aspirin is classified as an antiplatelet  
19 agent, not an anticoagulant). An INR was ordered to measure his anticoagulation  
20 status. His INR was elevated at 1.5, which is compatible with taking warfarin;  
21 but that level is not in the fully therapeutic range for the treatment of A-fib. An

1    EKG showed A-fib but was negative for acute findings. Tibia/fibula x-rays of the  
 2    left leg were obtained which did not show evidence of an acute fracture but were  
 3    read as showing "Diffuse [left] lower extremity edema ..." A chest x-ray showed  
 4    mild prominence of the central vasculature *without* overt changes of pulmonary  
 5    edema. At 1:00pm, SW was given Lasix 80mg orally for his edema, and he put  
 6    out 700ml of urine by 3:30pm. At 3:35pm, SW was given warfarin 5mg orally  
 7    plus a second anticoagulant, enoxaparin (low-molecular weight heparin –  
 8    tradename Lovenox), which was given as a 100mg subcutaneous injection.  
 9  
 10

12    8. A Doppler ultrasound (U/S) of the left leg to rule-out deep vein  
 13    thrombosis (DVT) could not be done at the VA Medical Center, and SW was sent  
 14    to Holy Family Hospital (HFH) by ambulance to have that test done at 5:40pm.  
 15    The injection of enoxaparin, noted above, was given as prophylaxis for possible  
 16    DVT pending the results of the U/S. At 6:03pm, Dr. McManus went off-shift and  
 17    turned the care of SW over to Dr. Medford Cashion. In his deposition, Dr.  
 18    McManus stated that he had intended to admit SW to the hospital regardless of  
 19    the U/S findings; and he communicated that intent to Dr. Cashion. (McManus  
 20    Depo 43:20 – 44:21)  
 21  
 22

24    9. SW returned to the VA Medical Center at 6:45pm, and the records  
 25    do not indicate that a DVT was found. Dr. Cashion's diagnostic impression was:  
 26

1 "Strain and contusion left knee." Dr. Cashion noted that SW had crutches with  
 2 him and had a knee immobilizer at home. In the ED, SW was able to walk using  
 3 only one crutch. SW was discharged from the ED with instructions to use his  
 4 crutches and knee immobilizer, and he was given a referral to follow-up in the  
 5 orthopedic clinic. He left the ED at approximately 8:05pm. (VAMC pg. 41).

6  
 7 10. After leaving the ED but while still in the hospital parking lot, SW  
 8 had an unwitnessed fall. Matthew Haugen, RN was just leaving the hospital after  
 9 having finished his day shift. He did not see SW fall but noticed him standing by  
 10 a wheelchair rack some distance from the hospital doors. Nurse Haugen  
 11 remembered that SW "was just standing there," "seemed unclear about his  
 12 situation," and "implied that he was driving [that is, that he would be driving  
 13 himself home from the parking lot]." (Haugen Depo 11:16 – 12:20) Nurse  
 14 Haugen felt that SW was "alert" and did not feel that he appeared "dazed"  
 15 (Haugen Depo 12:25 – 13:4); instead, he described SW as being "stalled."  
 16 (Haugen Depo 25:5-14) Nurse Haugen put SW in a wheelchair, wheeled him  
 17 back into the ED, and presented him to the triage nurse to be cared for.

18  
 19 11. Elizabeth Whitley-Ford, RN was the triage and charge nurse that  
 20 evening. She did not document and does not remember her conversation with  
 21 Nurse Haugen. (Whitley-Ford Depo 22:4-15) Her "Chief Complaint" triage note  
 22

1 was time-stamped 8:50pm on 8-2-14. It stated: "Pt dc'd home, was walking out to  
2 POV with ride home on crutches, lost footing and fell forward into bike rack  
3 [sic], going between bars and hitting head on ground. Lacerations, skin abrasions  
4 to rt [sic] forehead, bump to rt [sic] forehead. No LOC, minimal bleeding to  
5 forehead. Pt alert and oriented, denis [sic] pain, just scrape to head, requesting to  
6 go home now."  
7

8  
9 12. Nurse Whitley-Ford's physical assessment documented that SW was  
10 "alert and oriented X 3," that his eyes showed "PERRL," and that the forehead  
11 displayed "abrasion tort [sic] forehead, bump tort [sic] forehead." That note was  
12 entered into and/or signed in the computerized patient record system (CPRS) at  
13 11:18pm.  
14

15 13. SW was seen, again, by Dr. Cashion who documented this history  
16 at 8:43pm: "70m c/o head injury. He was discharged from this ER, and was using  
17 his crutches, when he fell into the bike rack [sic] out in our parking lot having  
18 tripped. A witness says his head went through the bike rack. Pt states his head hit  
19 the pavement but he wasn't knocked out. He has no headache and no neck or  
20 back pain, in fact no new pain." Dr. Cashion did not mention the presence or  
21 absence of an alteration in mental state (i.e. feeling dazed, disoriented or  
22 confused), amnesia, or other signs of concussion while SW was still in the  
23  
24  
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26

1 parking lot immediately following the blow to the head. The physical  
2 examination in the ED revealed a "3x4 cm fresh abrasion, mild swelling left  
3 upper forehead," and the neurologic exam was normal with "Mental status  
4 normal for age; PERRL, moving all 4 extr well." Interestingly, the extremities  
5 were now documented as showing "no sign injury."  
6  
7

8 14. Dr. Cashion's diagnostic impression was "Head injury, without  
9 concussion, contusion forehead, on warfarin" (Spokane VAMC pg. 16)<sup>1</sup>, and his  
10 "Assessment & Plan" were "Abrasion and contusion forehead, without  
11 concussion, on warfarin, today's INR 1.5. Pt and friend comfortable with home  
12 observation. Instruction sheet. Followup urgent care Aug 4." (Spokane VAMC  
13 pg. 25) That instruction sheet, however, is not in evidence as part of the medical  
14 records; and Nurse Whitley-Ford cannot recall talking to SW about the risks of  
15 bleeding into his head. (Whitley-Ford Depo 74:18 – 75:24) SW was given a  
16 tetanus booster on re-admission to the ED at 8:50pm; and he was discharged  
17 from the ED sometime around 11:00pm, although the precise time of discharge  
18 was not recorded.  
19  
20

21 15. SW was found lifeless in his bathtub on the morning of 8-3-14. An  
22 autopsy was performed by Jeffrey M. Reynolds, MD on 8-7-14. He found:  
23  
24

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25 26 <sup>1</sup> Excerpts from the medical records referenced in this Declaration are attached as Exhibit "A" to the  
Declaration of Richard C. Eymann.

1 "Superficial abrasion is present on the left frontal scalp, measuring 2 x 4 cm.  
 2 Only mild swelling present in this area ... No damage to the scalp is visible or  
 3 palpable." (Autopsy Report pg. 2) "No other evidence of head trauma is present."  
 4 (Autopsy Report pg. 4) However, once the skull was opened, Dr. Reynolds found  
 5 that "...a large (198 cc) subdural hematoma is present on the right with an  
 6 obvious left shift of the brain and pressure phenomena affecting the right  
 7 frontoparietal region." His final pathologic diagnoses included "Large, acute right  
 8 frontoparietal subdural hematoma," and the Cause of Death was listed as "Acute  
 9 subdural hematoma secondary to fall and anticoagulation." A Certificate of Death  
 10 was completed by the coroner, Peter J. Martin, on 8-11-14 and reflected the  
 11 findings noted at autopsy with the exception that the Certificate of Death listed  
 12 the time of death as 12: 30am on 8-3-14, and the Autopsy Report listed the time  
 13 of death as 9:30am on 8-3-14.  
 14

15 **II. Standard of Care**  
 16

17 16. One of the issues in this case is the degree of head and/or brain  
 18 injury that SW suffered. The American College of Emergency Physicians  
 19 (ACEP) 2008 Clinical Policy: Neuroimaging and Decision Making in Adult Mild  
 20 Traumatic Brain Injury [TBI] in the Acute Setting makes this enlightening  
 21 comment (see referenced article, page 715): "Terms used have included  
 22

1 "concussion," mild "TBI," "class I TBI," and "low-risk TBI." Even terms "head"  
 2 and "brain" have been used interchangeably. Head injury and TBI are 2 distinct  
 3 entities that are often, but not necessarily, related. A head injury is best defined as  
 4 an injury that is clinically evident on physical examination and is recognized by  
 5 the presence of ecchymosis, lacerations, deformities, or cerebrospinal fluid  
 6 leakage. A traumatic brain injury refers specifically to an injury to the brain itself  
 7 and is not always clinically evident; if unrecognized, it may result in an adverse  
 8 outcome."

11  
 12 17. The commonly used term "concussion" (synonymous with mild  
 13 TBI) is best described as an alteration in mental state (i.e. feeling dazed,  
 14 disoriented or confused up to and including a transient loss of consciousness)  
 15 associated with trauma to the head with or without amnesia of the traumatic event  
 16 and events immediately preceding and/or following the injury. One does not have  
 17 to lose consciousness to qualify as having suffered a concussion type TBI.  
 18

20 18. It is clear from Nurse Whitley-Ford's and Dr. Cashion's notes that  
 21 SW had head trauma that resulted in visible, external injuries to his forehead. The  
 22 question as to whether or not he had brain injury should have been assessed via:  
 23 1) a probing History of the Present Illness (HPI), 2) a thorough neurologic  
 24 Physical Examination (PE), and 3) brain imaging if indicated.  
 25

1       19. The HPI should have included SW's answers to questions such as:  
2       Did you feel dazed, disoriented or confused after hitting your head? Did you see  
3       stars or lights? Do you remember what made you fall [immediate pre-event  
4       memory vs. amnesia]? Do you remember hitting your head [memory of vs.  
5       amnesia for the event]? Do you remember how you got up from the fall  
6       [immediate post-event memory vs. amnesia]? The chart documents that SW was  
7       alert and oriented at the time of his re-admission to the ED, but it does not appear  
8       that either Nurse Whitley-Ford or Dr. Cashion asked the questions noted above  
9       other than Nurse Whitley-Ford's reporting that SW "lost footing" and Dr.  
10      Cashion's note regarding SW's "having tripped." No one charted Nurse Haugen's  
11      impressions that SW was just standing there as though he were stalled, that he  
12      seemed unclear about his situation, or that he seemed confused about who was to  
13      drive him home. Without asking all of the questions noted above and assessing  
14      the answers, no medical provider could know whether this visible, external  
15      forehead injury caused a concussion/mild TBI or not. Failing to ask those  
16      questions and record the answers was below the standard of care in emergency  
17      medicine.

24       20. The neurologic examinations that were performed by Nurse  
25      Whitley-Ford and Dr. Cashion were adequate with Nurse Whitley-Ford's exam  
26

1 (the better of the two) documenting that SW could move against gravity and had  
 2 normal grips and ability to push his feet [against resistance?] in addition to his  
 3 being A&O x 3 with PERRLA. What is conspicuously missing from each of their  
 4 PEs is a Glasgow Coma Scale (GCS) score. However, from the exams that are  
 5 documented regarding SW's mental status once he was back in the ED, it is likely  
 6 that his score was normal at 15.

9 21. That leaves us with the third component of assessment - imaging.  
 10 Mild TBIs associated with findings such as a GCS of 15, no focal neurologic  
 11 deficit, and no protracted vomiting do not usually require imaging *unless* the  
 12 patient is over 60-years-of-age or has a coagulopathy (alteration of normal  
 13 clotting as in someone who is taking warfarin, aspirin, and has recently been  
 14 injected with enoxaparin). Under those circumstances, as noted on page 718 of  
 15 the 2008 ACEP Clinical Policy: Neuroimaging and Decision Making in Adult  
 16 Mild Traumatic Brain Injury in the Acute Setting, a noncontrast head CT is  
 17 indicated as a Level A recommendation (Level A recommendations are  
 18 "Generally accepted principles for patient management that reflect a high degree  
 19 of clinical certainty (ie, based on strength of evidence Class I or overwhelming  
 20 evidence from strength of evidence Class II studies that directly address all of the  
 21 issues." - ACEP Policy page 717).

1       22. This mandate is reinforced by the findings of a 2003 study published  
 2 in *The Journal of Emergency Medicine* (see reference above) that clinical  
 3 findings (signs and symptoms) *cannot* reliably identify those patients with an  
 4 intracranial injury (ICI) secondary to minor head trauma (MHT). That study  
 5 noted: "Only 1 of 13 signs and symptoms correlated with ICI. In this study, no  
 6 useful clinical predictors of intracranial injury in elderly patients with MHT were  
 7 found. Current protocols based on clinical findings may miss 30% of elderly ICI  
 8 patients. Head CT scan is recommended on all elderly patients with MHT."

12       23. Treatment with enoxaparin, an anticoagulant, is a risk factor for  
 13 intracranial hemorrhage with minor head trauma in addition to the risks from  
 14 being anticoagulated with warfarin and having platelet function inhibited by  
 15 aspirin. From a 2002 study published in *The Journal of Trauma* (see reference  
 16 above): "These data indicate that the trauma patient with preinjury  
 17 anticoagulation such as warfarin or even aspirin who has an intracranial injury  
 18 has a four-to-fivefold higher risk of death than the nonanticoagulated patient."

21       24. Clearly, then, a CT scan of the head/brain was required in this  
 22 patient, and Nurse Whitley-Ford noted SW should have had a CT scan of his  
 23 head that night. (Whitley-Ford Depo 53:18 – 56:5) It is my opinion that a head  
 24 CT would have shown evidence of an intracranial hemorrhage in progress.  
 25

1 Failure to order a head CT was below the standard of care in emergency  
2 medicine.  
3

4 25. As already noted, Dr. Shea McManus thought that SW was ill  
5 enough that he ought to be admitted to the hospital even if the Doppler  
6 ultrasound of the leg were negative for DVT, which it was. Now, add to SW's  
7 baseline infirmities a fall that results in head trauma when he is already  
8 anticoagulated with two potent, pharmacologic agents plus aspirin. As noted  
9 above, it is my opinion that a head CT would have shown evidence of an early  
10 intracranial hemorrhage, which would have mandated neurosurgical consultation  
11 and admission/transfer. However, even if a CT scan done immediately after the  
12 head injury were not yet positive for the intracranial hemorrhage that killed him,  
13 SW still should have been admitted for observation.  
14  
15

16 26. As noted in the 2001 presentation to the *Annual Meeting of the*  
17 *Southeastern Surgical Congress* (see reference above): "In our experience  
18 treating the elderly anticoagulated trauma patient we have developed several  
19 practical guidelines to facilitate the acute care of these patients. All patients over  
20 age 65 who are on oral anticoagulation therapy are admitted and undergo head  
21 CT scanning even after an apparently minor head injury." And, in her deposition,  
22 Nurse Whitley-Ford said that she thought SW should have been admitted for  
23  
24 Nurse Whitley-Ford said that she thought SW should have been admitted for  
25  
26

1 overnight observation. (Whitney-Ford Depo 62:24) Dr. Cashion's failure to  
 2 arrange for SW to be admitted to the hospital was below the standard of care in  
 3 emergency medicine.  
 4

5 **III. Causation**

6 27. Per the Autopsy Report, SW's cause of death was "Acute subdural  
 7 hematoma secondary to fall and anticoagulation." It is more probable than not  
 8 that a head CT done at the time of the second ED visit would have shown an  
 9 intracranial hemorrhage in progress. The causation question arises, then, "Could  
 10 treatment have been rendered that would have prevented this awake and oriented  
 11 individual from going on to die from his intracranial hemorrhage?" The answers  
 12 involve dealing with the anticoagulation effects of warfarin and enoxaparin  
 13 (aspirin's effect cannot be reversed) and employing neurosurgical intervention,  
 14 should that treatment modality become indicated.  
 15

16 28. There are many different, life-threatening, bleeding emergencies  
 17 exacerbated by the presence of anticoagulants; and those patients are routinely  
 18 saved from exsanguination by the reversal of the effects of the blood-thinning  
 19 agents. Warfarin can be reversed with a combination of vitamin K and either  
 20 fresh frozen plasma (FFP) or prothrombin complex concentrate (PCC).  
 21 Compared to warfarin, enoxaparin has a relatively short half-life of only 4.5-  
 22  
 23  
 24  
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 26

1      hours. If it needs to be reversed immediately, that can be partially accomplished  
 2      with protamine sulfate; but even if nothing is done to reverse enoxaparin, its  
 3      effect rapidly wears off. Reversing the effects of warfarin and enoxaparin would  
 4      have decreased SW's tendency to continue bleeding.

5  
 6      29. As previously noted, SW's acute subdural hematoma (brain bleed)  
 7      should have been imaged with CT scanning, and SW should have been admitted  
 8      to the hospital to the service of a neurosurgeon or transferred to another hospital  
 9      that had neurosurgical capability. In my experience, neurosurgical management  
 10     of an acute subdural hematoma is usually successful in saving the patient's life  
 11     and preserving brain function. If bleeding stops before neurologic symptoms  
 12     develop, no surgical intervention is required. If the hematoma becomes large  
 13     enough to cause neurologic symptoms, the hematoma can be drained via a burr-  
 14     hole in the skull. If that is not feasible or effective, the bleeding can be addressed  
 15     in the operating room via a formal craniotomy.  
 16  
 17

18      30. It is more probable than not that reversing the anticoagulation effects  
 19      of warfarin and enoxaparin along with appropriate neurosurgical intervention as  
 20     needed would have prevented SW's death from his intracranial hemorrhage.  
 21     Failure to elicit an appropriate HPI and perform a head CT caused Dr. Cashion to  
 22     miss the brain bleed. Failure to admit SW to the hospital, even in the absence of  
 23  
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1 positive CT findings, obviated the chance to employ medical observation as a  
2 means of spotting SW's deterioration while there was still time to remediate it.  
3 Dr. Cashion's failures to meet the standard of care at all of these levels caused or  
4 significantly contributed to SW's death from brain hemorrhage.  
5

6 **IV. Standard of Care Opinion**  
7

8 31. Based on a reasonable degree of medical certainty and on a more  
9 probable than not basis, my opinion is that Dr. Medford Cashion fell below the  
10 standard of care in emergency medicine for the following reasons:  
11

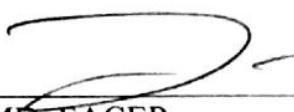
12 a. Failure to take an adequate History of the Present Illness;  
13 b. Failure to order a head CT;  
14 c. Failure to diagnose the intracranial hemorrhage; and  
15 d. Failure to arrange for Mr. Wright to be admitted to the hospital.  
16

17 **V. Causation Opinion**  
18

19 32. Based on a reasonable degree of medical certainty and on a more  
20 probable than not basis, my opinion is that Dr. Medford Cashion's failures to  
21 meet the standard of care in emergency medicine, as described and itemized  
22 above, caused Mr. Wright to be sent home from the ED with an unrecognized  
23 intracranial hemorrhage in progress, which caused his death.  
24  
25

1 I declare under penalty of perjury under the laws of the United States that  
2 the foregoing is true and correct.  
3

4 DATED this 3<sup>rd</sup> day of May, 2017, at Foster City, California.  
5

6   
7 Bruce Wapen, MD, FACEP  
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**CERTIFICATE OF SERVICE**

I hereby certify that on 5/8/17, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which will send notification of such filing to the following participants:

Rudy J. Verschoor	Rudy.J.Verschoor@usdoj.gov
Joseph Derrig	Joseph.Derrig@usdoj.gov
Amanda K. Thorsvig	Amanda@favros.com
Scott O' Halloran	Scott@favros.com

s/Richard C. Eymann  
**RICHARD C. EYMANN**

DECLARATION OF BRUCE WAPEN, M.D. IN OPPOSITION TO  
UNITED STATES' MOTION FOR SUMMARY JUDGMENT - 19

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